



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care



NATIONAL
GUIDELINE
CLEARINGHOUSE

General

Guideline Title

Practice parameter on disaster preparedness.

Bibliographic Source(s)

Pfefferbaum B, Shaw JA, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on disaster preparedness. J Am Acad Child Adolesc Psychiatry. 2013 Nov;52(11):1224-38. [137 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [March 22, 2016 – Opioid pain medicines](#) : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Principle 1. Clinicians should use the principles of psychological first aid, the primary intervention used during the impact, and the immediate post-impact phase of a disaster.

Psychological first aid is a component of the public health, mental health, medical, and emergency response systems, which recognizes that the foremost concerns during the impact phase and in the immediate aftermath of a disaster are safety, security, and triage. Psychological first aid can be administered by nonclinicians to address emotional stress until professional intervention is available. Psychological first aid should be ethnically, culturally, and developmentally appropriate to individual needs, striving to foster resilience and the natural impetus for recovery.

Psychological first aid focuses on basic physical and psychological needs by decreasing physiological arousal; offering and mobilizing support and psychosocial assistance; providing accurate and timely information about disaster reactions and available resources; and conducting ongoing assessments of functional status, triage, and referral. Intrinsic to psychological first aid are elements of crisis intervention that foster the titrated expression of the child's experience verbally or symbolically, restore the child's psychological equilibrium, normalize activities, and encourage the child's attempts to obtain help from others when needed. Children should not be encouraged to talk about or relive the event unless they are comfortable doing so.

A major component of early intervention and psychological first aid is triage. Some individuals will need behavioral assessment at the initial disaster triage site or victim reception area. The task is to screen, assess, and move survivors along a behavioral treatment timeline expeditiously, identifying those needing services, such as crisis intervention, psychopharmacological support, and/or referral for further assessment, and more intensive behavioral management. A computerized rapid triage model, Psychological Simple Triage and Rapid Treatment (PsySTART), uses risk data to link children to a continuum of interventions through various emergency medical services; public health, mental health, and specialized disaster programs; and disaster relief agencies.

Available Psychological First Aid Intervention/Materials

The National Child Traumatic Stress Network (NCTSN) and National Center for Posttraumatic Stress Disorder (PTSD) developed a modular approach to psychological first aid for use by mental health responders in diverse settings under diverse conditions. The American Red Cross (ARC), the International Federation of Red Cross and Red Crescent Societies, and other groups have published materials on psychological first aid. One model, "Listen, Protect, and Connect," provides guidance to parents, teachers, and others in implementing psychological first aid. Although psychological first aid is informed by evidence, empirical studies are needed to establish the efficacy and effectiveness of these interventions. Preliminary evaluation of the NCTSN and National Center for PTSD *Psychological First Aid* showed that it was considered an appropriate intervention and was not seen as harmful, and that training about the intervention increased provider confidence in working with children and adults.

Principle 2. Clinicians should use psychological debriefing only with caution.

Although the term *psychological debriefing* is used inconsistently, in general, the intervention is intended to facilitate prevention and recovery by normalizing reactions, creating a coherent narrative of the event, integrating the experience, sharing and validating emotions, and mitigating stress. The intervention as traditionally conceived is delivered in the early aftermath of an event in a single group session in which survivors share their experiences and reactions, reconstruct the event, and discuss coping strategies. This approach to debriefing is currently the subject of intense debate because of concern that it may increase arousal and feelings of helplessness and lead to maladaptive behaviors. Studies have shown that adults receiving psychological debriefing may not benefit psychologically compared with controls and in some instances may do worse. The lesson from adult debriefing studies is that in some cases, natural recovery with no intervention may be superior to any intervention or to the wrong intervention.

Debriefing has received less attention in children. The few available child debriefing studies have not all evaluated the traditional approach to debriefing delivered in a single group session in the early aftermath of a disaster, and the reports on these studies have provided minimal detail about the structure and content of debriefing sessions. Methodologic limitations in these studies also have prevented the investigators from drawing definitive conclusions about the benefit of the interventions used.

Although there are few empirical data to support psychological debriefing with children, anecdotal evidence suggests that, if used, debriefing should not occur in the immediate aftermath of disaster, when numbness and arousal may be prominent. The child's age and the type and degree of exposure should be among the factors considered when conducting group debriefing. Participation should be voluntary and with the consent of the parents or caretakers. Care must be taken to avoid exposing children to information and emotions that they cannot process or integrate to avoid re-traumatizing them through re-exposure to their own experiences or exposure to the experiences of others. Parallel attention to parental concerns and education can be beneficial.

Principle 3. Specific therapeutic approaches in the intermediate post-impact phase of a disaster include family outreach, psychoeducation, social support, screening, and anxiety reduction techniques.

Subsequent to the impact and immediate post-impact phases of a disaster, children often will benefit from interventions aimed at strengthening resilience and the natural impetus to recovery. These therapeutic approaches provide opportunities to identify the spectrum of emotional reactions, facilitate appropriate grieving and coping, restore normative age-appropriate behaviors, and prevent the onset of maladaptive behaviors and mental disorders. Services may be delivered in various places, including family notification and support centers, shelters, schools, and health and mental health care settings.

Family Outreach

The disaster literature suggests that decisions about services for children are influenced by parental response, yet studies indicate that parents often underestimate the suffering of their children. Thus, family outreach that includes psychoeducation and information about services is a major component of disaster mental health efforts. Paraprofessionals typically engage children and families in places where they naturally congregate, such as at schools, faith-based gatherings, and primary care settings; through neighborhood canvassing; and through the media.

Psychoeducation

Psychoeducation is used after disasters to normalize disaster reactions, correct distortions and misperceptions, enhance the child's sense of control, encourage the use of family and social supports, promote positive adaptive coping, and assess risk and protective factors. Topics may focus on common psychological reactions, mediators affecting the course of recovery, grief reactions, and stress management techniques. Families should be given information about reactions and symptoms that signify the need for further evaluation.

Although no cause-and-effect relation should be assumed, studies have found an association between viewing disaster-related television coverage and posttraumatic stress in children. Research has yet to explore children's reactions to various digital network technologies, such as search engines, social networks, and texting. Thus, as part of psychoeducation, clinicians should inform parents about children's reactions to traumatic events and encourage parents to assist their children in processing emotions related to the disaster and media coverage, to reassure their children about safety, to limit and monitor their children's exposure to media coverage, and to suggest and practice coping strategies.

Psychoeducation can be delivered informally or in formal structured presentations and may include written materials adapted for the event, age and developmental status, language, and culture. The media can disseminate information. Acknowledging that websites change over time, some organizations currently publish fact sheets and other useful information describing specific hazardous events and children's reactions to these events, information on recovery, and resources with contact information. These include [American Academy of Child and Adolescent Psychiatry \(AACAP\)](#) [redacted], the [American Academy of Pediatrics](#) [redacted], the [ARC](#) [redacted], the [Federal Emergency Management Agency \(FEMA\)](#) [redacted], the [National Association of School Psychologists](#) [redacted] and the [NCTSN](#) [redacted].

Psychoeducation also entails providing information to parents, teachers, responders, and public officials to encourage empathy, enhance social support, promote help seeking, and decrease the stigma associated with mental health services.

Social Support

Social support, defined as the "social interactions that provide individuals with actual assistance and embed them into a web of social relationships perceived to be loving, caring and readily available in times of need," is essential throughout all phases of a disaster. Providers should help families to access social supports and use community resources. Coping assistance, which is similar to social support, can be initiated by parents, teachers, and other child caretakers to enhance social interactions that promote a specific coping activity. Thus, children should be encouraged to talk to parents, teachers, and other caretakers. No single coping strategy is effective in all situations for all children, and multiple strategies may be used at once.

Screening

Psychological screening of survivors facilitates intervention by identifying those with the greatest need. Studies have provided preliminary evidence to support screening in child disaster survivors, but the appropriate timing of screening remains in debate, especially given the ubiquitous distress that accompanies disasters. The process of screening can stimulate dialogue about children's reactions and needs and can increase awareness about interventions. Screening is commonly conducted in school settings using tools to assess trauma exposure and internalizing and externalizing reactions with the goal of identifying children needing more comprehensive evaluation. Screening tools should be brief and uncomplicated, appropriate in content to the disaster phase and context, acceptable to those being screened, and easy to administer and score. Appropriate screening instruments are discussed in the [AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder \(PTSD\)](#) [redacted]. Problems associated with screening include its focus on illness rather than resilience, the potential inappropriate labeling of children, and the potential failure to identify some children in need of attention because their symptoms fluctuate.

Anxiety Reduction Techniques

The management of anxiety, which dominates the clinical presentation in the aftermath of a disaster, is an essential aspect of the therapeutic response. Maintaining routines to the extent possible may help allay anxiety. Specific behavioral anxiety reduction techniques commonly involve distraction and relaxation and cognitive coping strategies. For example, providers and parents can redirect children from troubling thoughts and emotions to more productive activities. Relaxation techniques typically use two approaches—breathing and muscle relaxation—and some also use guided imagery. Coping techniques used as part of a cognitive therapy approach involve teaching children the connections between their thoughts,

feelings, and behaviors and guiding them in developing adaptive thinking patterns.

Principle 4. The clinician should assess and monitor risk and protective factors to determine the child's vulnerability for psychological morbidity.

The evaluation of risk and monitoring of psychological responses occur across the disaster timeline. Informal assessment occurs on an ongoing basis as first-line responders, school personnel, pediatric and primary care providers, public health professionals, mental health providers, and volunteers interact with children and families. Formal assessment also may be indicated.

Clinical Assessment

The family's response to a disaster affects the child's response, and the child's response reciprocally influences the family's adaptation. Thus, the child should be evaluated in the context of the family. Clinical assessment entails a personal interview with the child and parent(s) and can be aided by information from other sources (e.g., teachers). The parent interview should clarify the nature, severity, and duration of the child's and family's disaster exposure and experience; identify the inventory of stressors; examine the spectrum of possible behavioral, mood, and anxiety symptoms and other psychological morbidities and somatic ills, including multiple unexplained physical symptoms; document the child's developmental and medical history; and enumerate important contextual mediators, such as social, religious, ethnic, and cultural factors.

Children should be asked directly about their experiences, reactions, and functional impairment. In most instances, children can recount their experience in words or use nonverbal means (e.g., play, storytelling, drawing) to relate what occurred. See the [AACAP PTSD Practice Parameter](#) for a discussion of issues arising in the assessment of childhood PTSD and for instruments that might facilitate the assessment process. To focus exclusively on posttraumatic stress symptoms, however, ignores the complex range of internalizing, externalizing, and somatic reactions that children may manifest in response to disasters and to associated losses and the cascade of secondary adversities that typically follow disasters. Thus, methods should assess the full spectrum of post-disaster psychological morbidities, including fear, anxiety, depression, and behavioral problems.

The child's cognitive and emotional development influences the expression of post-disaster reactions and thus the focus of the clinical assessment. With preschool and younger school-age children, the clinician often must make inferences regarding trauma reactions from manifest behaviors. For the preschool child, such behaviors may include clinging and dependent behaviors, phobic reactions, sleep and appetite disturbances, nightmares, loss of bladder and bowel control, agitation, temper tantrums, and hyperactivity. The younger school-age child may not verbalize psychological distress but may manifest it through play and behavioral symptoms, such as sleep and appetite disturbances, somatic complaints, concentration problems, irritability, hyperactivity, decrements in school performance, and sibling rivalry. Older children and adolescents have the capacity to express unpleasant internal emotional states and to describe their experiences verbally. The older child may present with hyperarousal, anxiety, panic, dysphoria and depressed mood, and maladaptive behaviors, such as belligerence and interpersonal conflict. The adolescent may present with depressed mood, social withdrawal, suicidal ideation and/or behavior, a sense of a foreshortened future, a flight into pseudo-independence, impulsive behavior, substance use or abuse, and/or hedonistic behavior.

Assessment of Reactions to Media Coverage

Professionals should conduct a media history to ascertain the amount and type of exposure to all forms of media coverage, including the Internet, social media, and computer-based media; to evaluate the content of, and reactions to, media coverage; and to determine the context of media exposure (e.g., children accessing coverage alone or in the presence of adults or peers).

Assessment of Resilience

Resilience is the capacity to rebound and to restore pre-disaster psychological equilibrium. The assessment of resilience is complicated by the necessity to define vulnerability and protective factors and to measure the different variables that mediate adaptation to adverse events.

Individual, family, and community factors contribute to resilience. Individual factors include one's neurobiology, the integrity of one's stress response system, and other individual dimensions, such as intelligence, cognitive ability, communication skills, social skills, locus of control, self-esteem, humor, hope, and optimism. Family factors associated with resilience include family cohesion, affectional ties within the family, and warm and caring parents. Community factors include caring social, community, school, and religious institutions.

Assessment Instruments

Assessment has been strengthened by instruments that measure disaster-specific stressors and reactions focusing on dimensions of exposure, stressors, emotional and behavioral reactions, family and psychosocial support, and attributions of causation. Instruments for screening and for evaluating posttraumatic stress symptoms are described in the [AACAP PTSD Practice Parameter](#) . Instruments are available to assess other outcomes.

Principle 5. Schools are a natural site for partnerships to conduct assessments of and deliver services to children exposed to disasters and for preparedness activities.

Schools provide access to children and they are a logical setting where trained personnel can assess psychological reactions to disasters and, when needed, provide mental health services, from prevention to individual and group counseling. Establishing disaster services in schools requires coordination with community-based providers. Ideally, work with schools begins before a disaster occurs through, for example, school crisis response teams that can foster collaboration between schools and community providers, prepare and empower school personnel through training and resources, and promote preparedness and response. Appropriate services should be determined in conjunction with the involved school or school district based on factors, such as the extent of disaster destruction, the exposure of children and staff, and the availability of school and community resources. Addressing the needs of principals and teachers should be part of any school-based effort because these individuals must contend with their own disaster experiences while simultaneously helping children in the schools. Barriers to school-based services include concern among school personnel that mental health efforts might re-traumatize children by exposing them to traumatic reminders and that disaster efforts may divert time from learning activities.

The school setting can be the site of a disaster as when damaged by natural events or is the focus of human-generated violence, such as the target of a bombing. Preparedness, response, and recovery strategies should consider this potentiality through contingency planning and specific interventions. Disaster preparedness programs in schools increase awareness of disasters and provide preparatory prevention activities.

Principle 6. Clinicians should preferentially consider multimodal disaster interventions that have the strongest evidence base.

Over time, most survivors will restore pre-disaster psychological equilibrium. In some children, psychological syndromes may slowly crystallize and impair the child's capacity to meet the demands of everyday life in the home, school, or social domains. These children and their families may require enhanced and sustained therapeutic interventions.

The choice of disaster intervention modalities for children is determined by the child's disaster exposure, psychological reactions, and preexisting conditions and by the presence of psychological comorbidities. Disaster interventions generally focus on posttraumatic stress reactions, anxiety and fear responses, depressive symptoms, grief reactions, behavior problems, school functioning, and overall coping and adaptive strategies. Many child disaster interventions that have been studied use multimodal, modular, and manual-guided approaches with components using social support, psychoeducation, construction of a trauma narrative, cognitive-behavioral techniques, coping skills enhancement, and problem-solving skills. These interventions have been delivered to individual children, to children in small groups, or in some combination of individual and group sessions.

The [AACAP PTSD Practice Parameter](#) identified trauma-focused cognitive-behavioral therapy and Cognitive Behavioral Intervention for Trauma in Schools (CBITS) as the best supported currently available trauma-focused therapies.

Some disaster reactions, such as depression, may occur secondary to intractable posttraumatic stress or in response to secondary adversities or other hardships in the aftermath of disaster and over time. In other instances, the presence of severe and enduring posttraumatic stress and/or other symptoms may require more traditional psychiatric interventions to decrease clinically maladaptive emotions and behaviors. These may include cognitive-behavioral and projective techniques, play and psychodynamic approaches, family and group interventions, and medication if indicated (see Principle 7 below).

When disasters result in the death of loved ones, the child and family must confront the reality and meaning of loss in their own life experiences. Grief is a normal reaction to loss for which bereavement support rather than formal treatment may be indicated.

Indicators for formal psychiatric treatment after traumatic loss include previous emotional or behavioral problems; current depressive, anxiety, and behavioral symptoms that interfere with the child's development; and/or trauma symptoms that interfere with the child's ability to mourn the loss. Approaches range from acute crisis intervention and brief supportive therapies to more intensive therapies involving cognitive-behavioral, psychodynamic, play, and psychopharmacologic approaches.

Guided activity workbooks with projective and other cognitive behavioral techniques have been used with children after disasters. These include, for example, *Helping Children Cope with Disasters*, *Healing After Trauma Skills (H.A.T.S.)*, and *My Hurricane Katrina and Rita Story: A Guided Activity Workbook for Children and Teenagers*.

Individual Treatment of Children

Individual treatment of children in clinical practice, as opposed to, for example, school-based interventions, should rely on a careful ongoing assessment of the child and family with attention to comorbid conditions (see Principle 4 above). In many disaster situations, individual treatment is not practical but may be necessary for children with pre-existing and/or enduring conditions for whom the intense and sustained relationship with the therapist is essential. In practice, psychodynamic approaches are commonly interwoven into interventions with the goal of understanding the meaning that the child imposes on the disaster experience and how the experience resonates with the child's other experiences, prior trauma,

defense mechanisms, and coping strategies.

It is prudent to be conservative and to support the natural impetus to recovery. Therapists should avoid interventions that may be excessively arousing and those that attribute pathology to normal stress reactions. It is wise to acknowledge and build on the child's adaptive psychological defenses and coping skills and on natural support structures and to avoid confronting the child prematurely with arousing stimuli. Sometimes, families initiate but fail to continue in treatment. Thus, clinicians are advised to assess barriers to families' commitment to treatment, explore potential treatment avoidance and noncompliance, and consider delivering each session with the possibility that the child and family may not return for additional work.

Family Intervention

When possible, children exposed to disasters should be evaluated and treated in conjunction with their families. It may be helpful for families to create a family trauma narrative, a process that requires family members to work together, thus facilitating communication and enhancing family coping. Some investigators have described family intervention strategies after trauma exposure, but these accounts generally recommend therapeutic approaches and present anecdotal case reports without empirically documented efficacy.

Group Interventions

Group work is ideal for educating children and their parents about disaster reactions and recovery, especially when large numbers of children must be reached. Sharing with other children who have similar experiences can reassure children who are hesitant to disclose their concerns or who believe their experiences are unique. Groups vary with respect to structure and the use of projective techniques. The group format provides opportunities to reminisce and explore loss, view various stages of recovery, observe coping strategies used by others, and gain the satisfaction of helping others. Certain topics, such as common reactions to trauma, traumatic reminders, anniversaries, and coping mechanisms, should be addressed even if not directly raised by participants. Group work serves as a forum for case identification. Group therapy may be particularly good for addressing intrusion symptoms, perhaps because children ventilate feelings that can be validated. The therapist must set limits on the expression of anger and aggression to avoid increasing anxiety for some children. Some children are uncomfortable with the group format and some need individual treatment. Group discussions may distress children when reminded of their own experiences and when learning about the experiences of others. Children also may adopt the coping techniques of other children before fully examining their own reactions or potential coping strategies.

Principle 7. Clinicians may consider psychopharmacologic interventions as adjuncts to other interventions for children with severe reactions or coexisting psychiatric conditions.

Psychopharmacologic interventions are reserved for severe indications and for coexisting psychiatric conditions that warrant intervention. See the [AACAP PTSD Practice Parameter](#) for a discussion of appropriate considerations in determining the need for, and appropriate use of, psychoactive medications for traumatized children. Most stress reactions are a normal response to disaster and it is generally judicious to allow a reasonable period for recovery before considering psychopharmacologic intervention. When used, medications should be considered an adjunct to psychotherapeutic interventions and should focus on target symptoms, such as acute onset of sleep disturbances, anxiety, depression, agitation, or aggressive behavior, that impair the child's capacity to meet the demands of everyday life. A careful assessment is necessary to identify target symptoms, and a risk-benefit analysis should be conducted before using medication.

Selective serotonin reuptake inhibitors have a favorable risk-benefit profile and may be effective in treating comorbid anxiety and depression. There may be some risk in using selective serotonin reuptake inhibitors because these drugs are sometimes associated with an activation syndrome manifested by irritability, restlessness, decreased sleep, daytime drowsiness, inattention, and somatic symptoms such as headache, stomachache, or nausea. Although benzodiazepines are not usually recommended for use in children, they may decrease anxiety and improve sleep, but there is no evidence that they alter the progression of psychological reactions over time. In addition, children treated with benzodiazepines may experience sedation, irritability, and disinhibition, and they are at risk for withdrawal symptoms.

There has been some interest in exploring psychopharmacologic interventions for trauma that might mitigate the risk for PTSD symptoms. For example, antiadrenergic drugs (e.g., propranolol), which can block the memory-enhancing effects of stress hormones, and cortisol, which can diminish memory retrieval, have been shown to decrease risk for PTSD symptoms in adults. A randomized control study, however, found no superiority of a β -blocker (propranolol) or an anxiolytic anticonvulsant (gabapentin) over placebo in preventing risk for PTSD symptoms in adults with severe physical injuries requiring specialized emergent treatment. Another study found that injured children who were treated with morphine for severe pain were less likely to have PTSD symptoms at 3-month follow-up, although the mechanism of action is not entirely clear.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Psychological reactions to disasters

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Prevention

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Guideline Objective(s)

To describe prevention, assessment, and intervention strategies to meet the emotional needs of children and families affected by disasters

Target Population

Children and families affected by disasters

Interventions and Practices Considered

1. Psychological first aid intervention and materials
2. Cautious use of psychological debriefing
3. Family outreach, psychoeducation, social support, screening, and anxiety reduction techniques (post-impact phase)
4. Assessment and monitoring of risk and protective factors to determine the child's vulnerability for psychological morbidity
5. Partnership with schools to conduct assessments and deliver services
6. Use of multimodal (individual, group, and family) disaster interventions
7. Psychopharmacologic interventions as adjuncts to other interventions

Major Outcomes Considered

- Impact of specific therapeutic approaches on disaster reactions
- Presence and degree of psychological morbidity (e.g., anxiety, depressed mood, maladaptive behaviors)
- Impact of traumatic events on children with coexisting psychiatric conditions or severe reactions

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The literature search was conducted in November 2009 using PubMed, MEDLINE, PsycINFO, EBM Reviews (evidence-based medicine), EMBASE (biomedical and pharmacologic), ERIC (education), and Social Work Abstracts. The search in MEDLINE and PsycINFO combined the following search terms: "child" OR "adolescent*" OR "teen" OR "youth" AND "disaster," yielding 1,926 results, which totaled 1,766 when duplicates were removed and 1,631 when the search was limited to the English language. These results were then limited to "humans," "all child (0–18 years)," "review articles," "treatment," and "prevention," yielding 320 results. When limited to "core clinical journals," 220 results were produced. This search was repeated in the EBM Reviews (evidence-based medicine database) and EMBASE (biomedical and pharmacologic database), resulting in 118 articles, and in ERIC (education), yielding 122 results. In Social Work Abstracts, the subject term "disaster" was limited to child and adolescent populations, yielding 31 results.

The PubMed database was searched independently to make full use of the MeSH term database. In PubMed, MeSH terms were used to narrow the search results. The MeSH term "disaster" was used, and those results were limited to "children 0–18 years," "human," and "English," yielding 6,101 results. When these were limited to "randomized controlled trials" or "meta-analyses," 131 results were found. Continuing in PubMed, a search using the MeSH term "terrorism" yielded 653 results when limited to "all children (0–18)." When these results were limited to "English," "meta-analyses," "randomized controlled trials," and "reviews and practice guidelines," 89 results were identified.

The PsycINFO database also was searched independently to take advantage of the unique subject headings used in this database. In PsycINFO, the "disaster" subject heading was combined with the subject heading of "treatment," which yielded 77 results. When these were limited to children and adolescents, 18 results were returned. "Disaster" was combined with "mental health" and limited to children and adolescents, yielding 20 results. The subject headings "posttraumatic stress disorder" (PTSD) and "treatment" were combined and yielded 78 results using the same limits. A search of the subject headings "grief" and "treatment outcomes" yielded 53 results, and 7 results when limited to children and adolescents. The

subject headings "posttraumatic stress disorder" and "drug therapy" yielded 58 results when limited to the child and adolescent population. Similar processes were used to review entries in the other databases. The MeSH term database in PubMed and the Subject Heading search in PsycINFO were searched to generate any new subject headings that had not been used previously.

In January 2013, an updated search using the same databases was conducted to identify materials published since November 2009. This search yielded an additional 63 publications.

Abstracts identified in the searches were reviewed to select material for potential inclusion in the parameter. Throughout the search process, the reference sections of review articles were examined to find any additional articles that were not generated in the search. In addition, studies of child disaster interventions described in refereed peer-reviewed journals were examined.

Reports and studies were included if they described interventions and contained sufficient information to ascertain their appropriateness for use with child disaster populations. Some interventions developed for nondisaster situations were included based on their current and potential application in the disaster context.

Number of Source Documents

See the "Description of Methods Used to Collect/Select the Evidence" field for the number of documents retrieved from each database searched.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are developed by the AACAP Committee on Quality Issues (CQI) in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP website. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.

AACAP develops patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when

available) and clinical consensus (when not) and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus. This Parameter is a clinician-oriented parameter.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

This parameter was reviewed at the Member Forum at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry (AACAP) in October 2010.

From October 2011 to October 2012, this Parameter was reviewed by a consensus group convened by the Committee on Quality Issues (CQI).

This Practice Parameter was approved by the AACAP Council on June 17, 2013.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of children and adolescents affected by disasters

Potential Harms

It is the responsibility of all mental health professionals who provide care during disasters to recognize their own capabilities, personal and professional limitations, and resources. Those who provide care are vulnerable to psychological stress and may, out of a sense of dedication, exhaust themselves in an effort to assist those in critical need.

Qualifying Statements

Qualifying Statements

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are developed to assist clinicians in psychiatric decision making. These Parameters are not intended to define the sole standard of care. As such, the Parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and other available resources.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Pfefferbaum B, Shaw JA, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on disaster preparedness. J Am Acad Child Adolesc Psychiatry. 2013 Nov;52(11):1224-38. [137 references] [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

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Financial Disclosures/Conflicts of Interest

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Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site](#) .

Availability of Companion Documents

None available

Patient Resources

The following are available:

- Helping children after a disaster. Facts for families. Washington (DC): American Academy of Child and Adolescent Psychiatry; 2008 Dec. Available from the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site](#) .
- Posttraumatic stress disorder (PTSD). Facts for families. Washington (DC): American Academy of Child and Adolescent Psychiatry; 2013 Oct. Available from the [AACAP Web site](#) .

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NGC Status

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